MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(4479

Reg. Dist. No. 21

P

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1833 Druid Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: ARMSTRONG - MOLLIE

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1895 ?

8. AGE:

Years	Months	Days	If less than one day
51 ?	unknown		--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER
12. Name: Isaac Sample
13. Birthplace: Virginia ?

MOTHER
14. Maiden name: Margaret Dorsey
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto City, Maryland

18. Funeral director: Mrs Ges H Holland

Address: 1631 Druid Hill Ave.

19. 5/17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1946, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1946, to May 15 1946 and that I last saw her alive on May 15 1946

Immediate cause of death	DURATION
Hypertensive Cardiovascular Disease	Known to us since 3/4/46
Due to: -------	
Due to: -------	
Other conditions: Senile Psychosis	Known to us since 3/4/46

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.: -----

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 5/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 1 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64480

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: W. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 4 Munroe Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: W. Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 Munroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alice Elizabeth Bailey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George C. Bailey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12th 1906

8. AGE:	Years	Months	Days	If less than one day
	40	0	4	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER — 12. Name: James R. Baxter

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: George C. Bailey

Address: W. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20th 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. May 20 1946 (Date rec'd by registrar) Registrar: W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1946 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1946, to May 16 1946 and that I last saw h[illegible] alive on May 15 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. J. Klawans, Md. M. D. or other

Address: 31 Southgate Ave. Date signed: 5/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04481

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Jewel, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Jewel
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles W. Bias

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Bias
13. Birthplace Md.

MOTHER
14. Maiden name Susie Stokes
15. Birthplace Md.

16. Informant Savanah Reid
Address Jewel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 21 46 (month) (day) (year)

Cemetery or crematory Carter's Chapel

Location Friendship, Md

18. Funeral director P.E. Sewell.
Address Prince Frederick, Md.

19. May 20 1946 (Date rec'd by registrar) H.W. Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-1946 at 1:00 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1946 to May 17 1946

and that I last saw h alive on 1946

Immediate cause of death	DURATION
Hypertension and heart disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [signature] Date signed May 22 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

04482

FILM No. 104 JUN - 6 1946

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 114 - Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Katherine Elizabeth Billingslea.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband ~~or wife~~: Dr. James S. Billingslea.
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): 6/14/82

8. AGE: Years	Months	Days	If less than one day
63	11	7	hrs. min.

9. Birthplace: Cambridge, Md.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business
FATHER 12. Name: Clement Bell
13. Birthplace: Cambridge, Md.
MOTHER 14. Maiden name: Unknown.
15. Birthplace
16. Informant: Dr. James S. Billingslea.
Address: Glen Burnie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 5/22 19 46 (Date rec'd by registrar) A.W. Hedrick DM. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21st 1946 at 8:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days.
Due to: Cardio Vascular disease	10 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op.
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: ——— Injured at work?

23. SIGNATURE: Gustav A. Bauhan M.D.
being medical examiner M. D. or other
Address: Glen Burnie Date signed 5/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D

CERTIFICATE OF DEATH

04483

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Green Haven, Pasadena, Md, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Green Haven, Pasadena, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fourth & Mayford Aves.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL E. BLOOM

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Ida V. Bloom
Nee Lamley 6.(c) If alive, give age: X years
7. Birth date of deceased (mo., day, yr.): December 9, ~~1946~~ 1870

8. AGE: Years	Months	Days	If less than one day
75	4	28	...hrs. ...min.

9. Birthplace: Howard Co. Md. (Town, county, and state)
10. Usual occupation: Retired Tavern Keeper
11. Industry or business: Own Business
FATHER 12. Name: Henry Bloom
13. Birthplace: Germany
MOTHER 14. Maiden name: Rachel - Unknown
15. Birthplace: Unknown
16. Informant: Earl S. Bloom
Address: Green Haven, Pasadena, Md. R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. 5/27 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 19 46 at 9.40A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/4/46 19 45 to 5/21/46 19 46
and that I last saw h[illegible] alive on 5/21/46 19
Immediate cause of death: Pulmonary Hemorrhage — DURATION
Due to:
Due to:
Other conditions: Carcinoma Lung
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: [signature]
M. D., or other
Address: 1123 St. Paul St Balto, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

04484

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:
20 College Ave.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 College Ave.
(If rural, give LOCATION)

2.(a) Ll veteran, name war: None

3.(a) FULL NAME: Margeret Fields Brooks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: William Brooks

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): October 2, 1906

8. AGE: Years	Months	Days	If less than one day
39			hrs. min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Joseph Fields
13. Birthplace: New York N. Y.

MOTHER
14. Maiden name: Ethel Davage
15. Birthplace: Annapolis Md.

16. Informant: Wm. Brooks Sr.
Address: 20 College Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/4/46 (month) (day) (year)

Cemetery or crematory: Saint Marys Cemetery

Location: West St. extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 2 19 4 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1946 at 2:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-8 1946 to 5-1 1946 and that I last saw h.er alive on 4-30. 1946

Immediate cause of death: Congestive heart failure.

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M. D. or other

Address: 17 Conduit St. Date signed 5-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C4485

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Spa Road Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred: Spa Road near annapolis Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Spa Road Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near annapolis

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lydia Jane Bullen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: John Fletcher Bullen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 30 - 1856

8. AGE: Years	Months	Days	If less than one day
89 ~~99~~	11	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: James Tanner

FATHER — 13. Birthplace: maryland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs John J. Purdy

Address: annapolis md R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16/46 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Baltimore md

18. Funeral director: B. L. Hopkins

Address: annapolis

19. May 16, 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1946, to May 13, 1946, and that I last saw h[illegible] alive on May 13, 1946.

Immediate cause of death	DURATION
Senility	5 yrs
Due to	
Due to	
Other conditions: Arterio Sclerosis	Several

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Albert A. Lee Anderson M. D. or other

Address: Annapolis Md Date signed: 5/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

C4486

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Ann Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Lafayette Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Bundy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	widow

6.(b) Name of husband or wife Wm. Bundy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace Ann Arundel Co. (Town, county, and state)
10. Usual occupation Seamstress
11. Industry or business

FATHER
12. Name Wm. Freeland
13. Birthplace Calvert Co.

MOTHER
14. Maiden name Eliza Booze
15. Birthplace Md

18. Informant Lloyd Bundy
Address 38 Lafayette Ave Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21 1946 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore Md.
18. Funeral director D.B. Johnson
Address Annapolis Md
19. May 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946, at 11:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1946 to May 17 1946 and that I last saw h alive on May 17 1946

Immediate cause of death	DURATION
Asphyxia	2 day
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore D. Johnson M.D.
M. D. or other
Address 40 Northwest Street Date signed 5/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

04487

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Glenburnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. Crain Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Bussey

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William F. Bussey

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	18	hrs. min.

9. Birthplace Posen Germany (Town, county, and state)

10. Usual occupation House Work

11. Industry or business Own Home

FATHER 12. Name August Tepper

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Augusta Knopp

MOTHER 15. Birthplace Germany

16. Informant Mrs. Frederick Ascgemeyer

Address Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25, 1946 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Cedar Hill, Brooklyn, Md. R.F.D.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 5/24 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1946 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to May 21 1946 and that I last saw h alive on May 21 1946

Immediate cause of death	DURATION
Cardio Vascular Disease	5 yrs.
Due to	
Due to	
Other conditions Grippe & Bronchitis	1 week

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bale Jr. M.D. M. D. or other

Address Linthicum Date signed 5-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04488

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs, 11 mos, 14 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yrs, 11 mos, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ----------
City or town: Baltimore City (?)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 446 High Street (?)
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: CASHWELL - DAVID

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Gladys Cashwell, 446 High St., Balto., Md. (?) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1913 ?

8. AGE: Years: 33 ? Months: unknown Days: ---
If less than one day: ---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER
12. Name: Ben Cashwell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mattie Sparrow
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-14-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville

18. Funeral director: Supt.
Address: Crownsville

19. May 14 1946 (Date rec'd by registrar) E. J. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 19 46 at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 39 to May 3 19 46 and that I last saw him alive on May 3 19 46

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 3/12/46
Due to: -------	
Due to: -------	
Other conditions: Paranoid Condition	Known to us since 5/19/39

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op. -------

Autopsy results: Lung tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of -------
Where did injury occur? ---------- (City or town) ---------- (County) ---------- (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ------- Injured at work? -----

23. SIGNATURE: Herbert V. Brinsfield M. D. or other
Address: Crownsville, Maryland Date signed 5/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

04489

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Millersville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Indian Landing Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Percival Edward Chamberlain (Adopted)
3.(b) Social Security Number: 217-09-8440

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Magda L. Chamberlain
Nee Baur
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): September 21, 1887

8. AGE: Years	Months	Days	If less than one day
62	7	3	....hrs. ....min.

9. Birthplace: Terra Houte Ind.
(Town, county, and state)
10. Usual occupation: Editor Public Relations (Retired)
11. Industry or business: Amer. Hammer + Piston Ring Co.

FATHER
12. Name: Kelly Monroe Turney
13. Birthplace: Unknown

MOTHER
14. Maiden name: Carrie Chamberlain.
15. Birthplace: ~~Millersville Md~~ Lima, Peru

16. Informant: Mrs. P.E. Chamberlain
Address: Millersville, Md. R.F.D.

17. Cremation (Burial, cremation, or removal, Which?) Date thereof: May 4, 1946 (month) (day) (year)
Cemetery or crematory: Louden Park
Location: Baltimore, Md.
18. Funeral director: Thomas W. Duglaton
Address: New Burnie, Md.

19. May 2 19 46 (Date rec'd by registrar) M. D. Allen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-1- 19 46 at 1 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29-46 19.... to 5-1 19 46 and that I last saw h~~im~~er alive on 5-1 19 46

Immediate cause of death	DURATION
Gastric hemorrhage	5 Day
Due to: Gastric ulcer	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. E. Williams M.D.
M. D. or other
Address: Annapolis Md. Date signed: 5-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of age of deceased is shown on

04490

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

FILE NO. 104 JUN - 6 1946

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town 1106 Mitchell St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eastport.
(If rural, give LOCATION)
2a. If veteran, name war

3. (a) FULL NAME Mary I. Collison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Joseph Collison
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept 6th 1863

8. AGE: Years	Months	Days	If less than one day
82	8	11	..... hrs. ..... min.

9. Birthplace St Mary's Co Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs Charles N. Brooks Jr.
Address 151 Main St. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20th 1946 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor, Son
Address Annapolis Md.
19. May 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946, at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to May 17 1946
and that I last saw h.. alive on May 17 1946
Immediate cause of death

	DURATION
(1) Chronic myocarditis	
(2) Nephritis, chronic glomerular	
Due to Duration 5 five years.	
Due to A.W.O.R.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. Lawlest Lawlest M. D. or other
Address Eastport, Md Date signed 5/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

04491

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Round Bay, Severna Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 hours

Hospital, institution, or street address where death occurred: Severn River Round Bay

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A A

City or town Arnolds (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Don Arthur Cowin

3. (b) Social Security Number

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 18 – 1930

8. AGE: Years 16 Months Days 13 If less than one day ... hrs. ... min.

9. Birthplace Wooster Ohio (Town, county, and state)

10. Usual occupation School Boy

11. Industry or business

FATHER 12. Name Allen W. Cowin

13. Birthplace Amherst Ohio

MOTHER 14. Maiden name Evelyn Van Oster

15. Birthplace Elyria, Ohio

16. Informant Allen W Cowin

Address Arnolds Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 3/46 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg Road

18. Funeral director B L Hopping

Address Annapolis Md.

19. June 3 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1946, at 5:35 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~I attended deceased from~~ Postmortem Examination ~~I last saw h... alive on~~ May 31 1946

Immediate cause of death	DURATION
Drowning	
Due to Accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/31/46.

Where did injury occur? Severna Park, A. A., Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Round Bay

Means of injury Drowning Injured at work? No

23. SIGNATURE John N. Claffy M.D., Deputy Medical Examiner (M. D. or other)

Address Annapolis, Md Date signed 6/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04492 20
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Clayborn B. Cox

3. (b) Social Security Number: 227-05-7967

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pauline A. Cox
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 25, 1901

8. AGE: Years: 45 Months: 0 Days: 1 If less than one day: hrs. min.

9. Birthplace: Princeton, West Virginia
(Town, county, and state)

10. Usual occupation: Timber Cutter

11. Industry or business: Lumber business

FATHER
12. Name: William H. Cox
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Emma Ruckman
15. Birthplace: West Virginia

16. Informant: Mrs. Pauline A. Cox
Address: Edgewater P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1946 (month) (day) (year)
Cemetery or crematory: Family M.E.
Location: Woodsonville Md

18. Funeral director: B-L. Hopkins
Address: Annapolis Md

19. May 28 1946 (Date rec'd by registrar) Elwood Collison Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1946, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination and that I last saw h... alive on May 27 1946

	DURATION
Immediate cause of death: Coronary embolism	Sudden
Due to: Coronary Sclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04493 23
Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Briiklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4500 Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LEONHARDT EBERSBERGER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louise Ebersberger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1885

8. AGE: Years	Months	Days	If less than one day
61	2	13	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Grocer
11. Industry or business:

FATHER
12. Name: Michael Ebersberger
13. Birthplace: Germany

MOTHER
14. Maiden name: Helena Schafer
15. Birthplace: Germany

16. Informant: Leonhardt Ebersberger
Address: 457 W. Meadow Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Anne Arundel Co.
18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St.,

19. 5-16-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1946 at 11 p M

21. I CERTIFY that death occurred on the date above stated; I last attended deceased from May 1 1946 to May 13 1946
and that I last saw him alive on May 13 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Arteriosclerosis, Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John G. Schmuck M. D. or other
Address: 1337 S. Clarke St. Date signed 5/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04494

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
45 Larkins St. Annapolis Md.
How long in hospital or institution? xxxxxxxxxxxxxxxx

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel C
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 45 Larkins St.
(If rural, give LOCATION)
2.(a) If veteran, name war: xxxxxxxxxxxxxxxx

3.(a) NAME: Emma Luretta Edwards

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1876

8. AGE: Years: 69 | Months: 11 | Days: | If less than one day: hrs. min.

9. Birthplace: Green Castel Penn. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Charles Wesley Campbell
13. Birthplace: Warren County Va.

MOTHER
14. Maiden name: Sally Frances Botts
15. Birthplace: Culpepper Virginia

16. Informant: Mrs Annie Johnson
Address: 45 Larkins St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/ 26/46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1946, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1946, to May 23, 1946, and that I last saw h[illegible] alive on May 23 1946.

Immediate cause of death	DURATION
Lobar Pneumonia	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. R. Richardson M. D. or other
Address: Annapolis Md. Date signed: 5/25/46

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

04495

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Waterbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Waterbury Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ida Edwards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Basil Edwards
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 26, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	11	hrs. min.

9. Birthplace: A.A. Co. Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: James Grossery
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Cuckaurs
15. Birthplace: Md.
16. Informant: Basil Edwards
Address: Waterbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18, 1946 (month) (day) (year)
Cemetery or crematory: John Wesley
Location: Waterbury, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis Md
19. May 18 1946 (Date rec'd by registrar) E.A. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1946 at 7:45 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15 1946 to May 15 1946 and that I last saw h[illegible] alive on May 15 1946
Immediate cause of death: Carcinoma of left breast — DURATION: 1 year
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H.L. Richardson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 5/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

★ 044228. Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 2 mos, 7 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs., 2 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: EDWARDS - MINNIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1904 ?

8. AGE: Years: 42 ? Months: unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: John Chavis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Haddy Ward
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof (month) (day) (year) 5/25-46
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt.
Address: Crownsville

19. (Date rec'd by registrar) May 24 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 46, at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 44, to May 9 19 46
and that I last saw her alive on May 9 19 46

	DURATION
Immediate cause of death: General Paresis	Known to us since 3/2/44
Due to: ---	
Due to: ---	
Other conditions: Carcinoma of Uterus	Known to us since 3/2/44

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Hubert V. Hawkins M. D. or other
Address: Crownsville, Maryland Date signed: 5/9/46

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04497

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a e

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred: 501 - 4th St Eastport

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a e

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 501 4th St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: mary Evelyn Fowler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 19 - 1893

8. AGE: Years	Months	Days	If less than one day
53	3	9	hrs. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business:

FATHER — 12. Name: Joseph C Fowler

13. Birthplace: Calvert Co

MOTHER — 14. Maiden name: Mary Ellen Stevens

15. Birthplace: Calvert Co

16. Informant: Leroy Fowler

Address: Eastport Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31/46 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Near Bolts Mills

18. Funeral director: A L Hopkins

Address: Annapolis Md

19. May 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1946 at 8.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 45 to May 28 1946 and that I last saw h.e.r alive on May 28 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Hypertensive C.V.D	2 yrs.
disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Calvert, Md Date signed: 5/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

04498

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

XS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 908 Creek Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Washington Freeman

3.(b) Social Security Number

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Louise Freeman
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 4, 1874
8. AGE: Years: 71 Months: 9 Days: 20 If less than one day: ..... hrs. ..... min.
9. Birthplace: Anne Arundel Co., Md. (Town, county, and state)
10. Usual occupation: waterman
11. Industry or business:
FATHER 12. Name: George Freeman
13. Birthplace: A.A. Co., Md.
MOTHER 14. Maiden name: Josephine Forman
15. Birthplace: A.A. Co., Md.
16. Informant: Mrs. Louise Freeman
Address: 908 Creek Dr., Eastport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: John H. Taylor & Son
Address: Annapolis, Md.
19. May 27 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25th 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1944, to May 25 1946 and that I last saw him alive on May 24th 1946

Immediate cause of death: Myocarditis fibrosis — DURATION: 2 mo

Due to: Cancer of Prostate — DURATION: 2 yrs

Due to: — DURATION:

Other conditions — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. T. Russell M. D. or other
Address: Eastport Date signed: 5-26-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

04499 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Md R.F.D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chesterfield Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Emil Gertz

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Amelia Anna Gertz.
Nee Abend 6.(c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.): April 16, 1872

8. AGE: Years	Months	Days	If less than one day
74	1	14	....hrs. ....min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Farmer (Retired)
11. Industry or business: OWN Farm.
FATHER 12. Name: Christian Gertz.
13. Birthplace: UNKNOWN
MOTHER 14. Maiden name: Elizabeth Schmidt.
15. Birthplace: UNKNOWN
16. Informant: Mr. Gertz.
Address: Crownsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Cedar Hill, Brooklyn Md
18. Funeral director: Thomas W. Derrickson
Address: Glen Burnie, Md.
19. June 1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1946, at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946, to May 30 1946 and that I last saw h[e] alive on May 15 1946

Immediate cause of death	DURATION
Heart failure	2 mos
Due to: Arteriosclerotic Heart Disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Williams MD
M. D. or other
Address: Annapolis Md Date signed: 5-30-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04500

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:
County A.A.
City or town Jewell
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md. County A.A.
City or town Jewell
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles E. Gray.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	c.	Married

B.(b) Name of husband or wife Mary Gray.
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May, 16, 1888

8. AGE: Years	Months	Days	If less than one day
58		20	hrs. min.

9. Birthplace md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Andrew Gray.

FATHER
12. Name md
13. Birthplace

MOTHER
14. Maiden name Rachelle Peters.
15. Birthplace md.

16. Informant Mary Gray.
Address Jewell md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-2-46 (month) (day) (year)
Cemetery or crematory Mt Zion
Location A.A. County.
18. Funeral director R.E. Lewell
Address Prince Frederick Md

19. May 31 1946 (Date rec'd by registrar) W.M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 19 46 at 4.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-Jan 19 46, to 5-30 19 46 and that I last saw h.. alive on 5-21 19 46

Immediate cause of death Chronic myocarditis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, indusfry, public place (where?)
Meane of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Huntingtown Md. Date signed May 4 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

04501

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. Co

City or town Pumphrey Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co

City or town Pumphrey Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. Robert St. Patapsco Park

(If rural, give LOCATION)

2.(a) If veteran, name war * World War One

3. (a) FULL NAME Frank J. Gray

3. (b) Social Security Number 217-05-4626

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Grace Gray

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct 7 - 1888

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name Leonard A. Gray

FATHER 13. Birthplace Frederick Co. Md

MOTHER 14. Maiden name Stella C. Young

MOTHER 15. Birthplace Loudon Co. Va.

16. Informant Grace Gray

Address Robert St. Patapsco Park

17. (Burial, cremation, or removal. Which?) Date thereof 5-6-46 (month) (day) (year)

Cemetery or crematory Mt. Auburn Cemetery

Location Baltimore Md

18. Funeral director Archibald A. Geddis

Address 2101 Pennsylvania Ave, Baltimore

19. 5/6/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3-46 19.... at 8:00 a. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-15 19 46, to 5-3 19 46

and that I last saw h.i.m alive on 5-3-46 19....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Includa pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death waa due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Julius S. White M. D. or other

Address 1802 Penna Ave Date signed 5-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

04502

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour, 44 minutes
Hospital, institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or institution? 1 hour, 44 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brown's Woods
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Dennis Harold

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lera Harold
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): December 25, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	22	hrs. min.

9. Birthplace: Portsmouth, Virginia
(Town, county, and state)
10. Usual occupation: Skilled laborer
11. Industry or business: Shipyard

MOTHER FATHER
12. Name: Raleigh Harold
13. Birthplace: Portsmouth, Virginia
14. Maiden name: Martha Harold (Maiden name ?)
15. Birthplace: Portsmouth, Virginia

16. Informant: Margaret Harold - daughter
Address: Brown's Wood, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22/46 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: St. Margarets
18. Funeral director: J. B. Ittman
Address: Annapolis, Md.
19. May 21 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1946, at 11:59P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Fracture of skull - fright	Sudden
Fracture of left thigh and foot.	
Due to: Being hit by automobile,	
Due to: which he (deceased) was	
riding on a bicycle.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/17/46
Where did injury occur? Annapolis - A.A. Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Severn Bridge.
Means of injury: hit by automobile Injured at work? No

23. SIGNATURE: Gustave A. Faucher M.D.
Acting Medical Examiner M.D. or other
Address: Glen Burnie Md. Date signed 5/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04503

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred: 5 School St nursing home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 School St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Kennedy Harrison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

B.(b) Name of husband or wife: anna Dora Harrison

B.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): aug 16 - 1879

8. AGE: Years	Months	Days	If less than one day
66 ~~76~~	8	29	hrs. min.

9. Birthplace: Balto md (Town, county, and state)

10. Usual occupation: Insurance

11. Industry or business

FATHER — 12. Name: Thomas M Harrison

FATHER — 13. Birthplace: balto md

MOTHER — 14. Maiden name: Katherine ann Ahern

MOTHER — 15. Birthplace: Balto. md

18. Informant: Anna Dora. Harrison

Address: 5 School St annapolis. md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: may 12/46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: annapolis md

18. Funeral director: B L Hopkins

Address: annapolis md

19. May 11 19 46 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 46, at 6.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 5 19 46 to May 9 19 46 and that I last saw h. alive on May 9 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: the heart	2 weeks
Due to:	
Other conditions: Arteriosclerotic Cardio-Renal Disease	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis Md Date signed: 5/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04504

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 17 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HILL - LAURA LEE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

8.(b) Name of husband or wife: ---

8.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1903

8. AGE: Years: 43 | Months: unknown | Days: | If less than one day: --- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: Theodore Thomas
13. Birthplace: unknown

MOTHER
14. Maiden name: Elma Williams
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 15, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill
Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Maryland

19. May 13, 1946 (Date rec'd by registrar) B F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1946, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 25, 1946 to May 12, 1946
and that I last saw her alive on May 12, 1946

Immediate cause of death	DURATION
General Paresis	Known to us since 3/25/46
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: --- Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Wm. T. Hinkle M. D. or other
Address: Crownsville, Maryland Date signed: 5/12/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04505

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis ~~Sudley~~ A. A. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, institution, or street address where death occurred:
Emergency Hospt. Annapolis Md.
How long in hospital or institution? Entered 5/11/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: West River A. A. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: None
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Evelyn Brown Howard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Walter Howard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1903

8. AGE: Years	Months	Days	If less than one day
42	9		..... hrs. ..... min.

9. Birthplace: Arnold A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Elijah Brown
13. Birthplace: Severn A. A. Co. Md.

MOTHER
14. Maiden name: Mary Jane Marshall
15. Birthplace: Arnold A. A. Co. Md.

16. Informant: Mrs Louise Johnson
Address: 43 Larkins St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Arnold Md.
Location: Mt. Calvary Church Cemetery Arnlod Md

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 16, 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1946, at 7 ~~A.~~ P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ~~last illness~~ Post mortem Examination 19..... and last saw ~~alive~~ on May 12, 1946

Immediate cause of death	DURATION
Concussion of Brain	
Due to Hemorrhage & Shock	
Due to Fracture of both Tibia	
Due to Fracture of Lft Humerus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/11/46
Where did injury occur? Deale Road (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Deale Road
Means of injury: Rt + Rms auto collision Injured at work? No

23. SIGNATURE: John M Caffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis Md Date signed 5/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04506

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? 3 Months and 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Johnson City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 440 Riverside Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN J. JACOBY (RA 6,687,850)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
White	Male	Single

6.(b) Name of husband or wife: (Sister) Mrs. Bernice Campbell,
77 Lilac St., New Haven, Conn. 6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): June 19, 1908

8. AGE: Years	Months	Days	If less than one day
37	10	21	..... hrs. ..... min.

9. Birthplace: New Haven, Connecticut (Town, county, and state)
10. Usual occupation: Soldier, U. S. Army (Technical
11. Industry or business: Regular Army /Sergeant)

FATHER
12. Name: Stanley Jakubowicz
13. Birthplace: Dzubley, Poland

MOTHER
14. Maiden name: Amila Niziolek
15. Birthplace: Dzunicy, Polane

16. Informant: U.S. Army Medical and Service Records
Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/11/46 (month) (day) (year)
Cemetery or crematory: Markiewicz Funeral Parlor
Location: Trumball St., New Haven, Connecticut

18. Funeral director: Howard W. Blight Jr.
Address: 4914 Belair Road.

19. 10 May 1946 (Date rec'd by registrar) ALLAN G. BROTZMAN, 2d Lt. MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 May, 1946, at 1110 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 26 Jan 1946 to 12 Feb 1946 and that I last saw h... in... alive on 10 May 1946

Immediate cause of death	DURATION
Ruptured gastric ulcer	
Due to: Severe vomiting	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Hemorrhage, acute, origin gastro- *
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

*intestinal tract, Probably stomach.

23. SIGNATURE: Frank W Countryman 1 Lt MC (M. D. or other)
Address: Reg. Hosp, Ft G G Mead. Md. Date signed: 13 May 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH ☆

04507

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs, 1 mo, 16 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 16 yrs, 1 mo, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Marion
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHNSON - CLARA

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 62 Months: unknown Days: If less than one day: ——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ———

FATHER
12. Name: Edward Rounds
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah E. Horsey
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21-1946 (month) (day) (year)
Cemetery or crematory: somerset co
Location: near marion md

18. Funeral director: Chas H Ward
Address: marion md

19. May 18 1946 (Date rec'd by registrar) E T Joyce Lowe - Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1946, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1930, to May 17 1946 and that I last saw her alive on May 17 1946

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us about 6 mos.
Due to: ———	
Due to: ———	
Other conditions: Schizophrenia - Paranoid type (Include pregnancy within 3 months of death)	Known to us since 3/31/30

Major findings of operations: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Robert J Brunkerhoff M. D. or other
Address: Crownsville, Maryland Date signed: 5/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (532)

04508

FILM No. I 04 MAY 27 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural, Brownwood, Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Brownwood R. 2,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George C. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Mary E. Johnson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1889

8. AGE: Years	Months	Days	If less than one day
57 56	6	4	hrs. min.

9. Birthplace Brownwood, A.A.Co. Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name James Standberry

13. Birthplace A.A. Co.

MOTHER 14. Maiden name Arnetta Johnson

15. Birthplace A.A. Co.

16. Informant ~~Boss~~ Mary Johnson

Address R. 2 Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1946 (month) (day) (year)

Cemetery or crematory Broadneck

Location Edgemore, Md.

18. Funeral director J.B. Johnson

Address Annapolis Md.

19. May 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1946, at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946, to May 14, 1946

and that I last saw h alive on 19

Immediate cause of death	DURATION
Apoplexy	7 days
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore H. Johnson M.D.

M. D. or other

Address 40 Northwest Street Date signed 5/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Mr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04509

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, lastitutioa, or street address where death occurred:

How loag la hospital or institutioa?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Annapolis Rural Beaverwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Irene Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1878

8. AGE:

Years	Months	Days	If less thaa oae day
68	2	29	..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or busiaess

FATHER — 12. Name: Thomas Brown

13. Birthplace: Va.

MOTHER — 14. Maidea aame: Rosetta Brown

15. Birthplace: Va.

16. Informant: Hester Walker

Address: Brawnwood rd R. 2 Box 420

17. Burial (Burial, cremation, or removal. Which?) Date thereof: may 9 1946 (month) (day) (year)

Cemetery or crematory: Broadneck, Brewer Hill

Location: Edgewater, Md Annapolis

18. Funeral director: J.B. Johnson

Address: Annapolis Md

19. May 9 1946 (Date rec'd by Registrar) W. D. Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1946, at 1 P. M

21. I CERTIFY that death occurrad on the date above stated: thet I attended deceased from May 4, 1946, to May 6 1946

and that I last saw h.er alive oa May 6 1946

	DURATION
Immediata cause af death: Apoplexy	2hrs.
Due to: Hypertension	6 mos
Due to:	
Other coaditioas:	

(Include pregnancy within 3 months of death)

Majar fiadings of operations: Date of op.

Aatopsy results:

PHYSICIAN: Please aaderline the caose tn which death shaafd be charged statistically.

22. VfOLENCE: If death was due fo exteraal causes, fill la the following:

Accideat, aaicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, fadustry, public place (where?)

Means of lajury: Iajured at work?

23. SIGNATURE: J. B. Johnson M. D. or other

Address: 40 Northern Ave Date sigaed: 5/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04510

CERTIFICATE OF DEATH

Reg. Dist. No. 2I

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Mt. Rd. Pasadena Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Pasadena Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mt. Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Walter D. Klingelhoefer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ethel J.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7 1900

8. AGE: Years: 46 | Months: 1 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Wm. W. Klingelhoefer

13. Birthplace: Baltimore Md.

MOTHER — 14. Maiden name: Julia Henry

15. Birthplace: Baltimore Co.

16. Informant: Mrs. Ethel J. Klingelhoefer

Address: Pasadena Md. Moutain Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 46 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Cem.

Location: Richhe Highway

18. Funeral director: Clarence Hoffman

Address: 1639 N. Broadway

19. 5-17 19 46 (Date rec'd by registrar) L. A. Dreit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 19 46 at 10.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 46 to May 17 19 46 and that I last saw him alive on May 13 19 46

Immediate cause of death	DURATION
Carcinoma of stomach	I year
Generalized metastatic carcinomatosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: inoperable carcinoma with many metastases. Date of op. Jan.-46

Autopsy results: ----- (gastro-enterostomy)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. A. Dreit. M.D. (M. D. or other)

Address: Pasadena, Md. Date signed: 5-17-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04511

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 years

Hospital, Institution, or street address where death occurred:
79 Spa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Spa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles G Koch

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Frida Koch

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Jan 24- 1867

8. AGE: Years: 79 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Trucker

11. Industry or business

FATHER
12. Name: Geo G. Koch
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Frida Koch
Address: 79 Spa Road, annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12/46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: B. L. Hopkins

Address: annapolis Md

19. May 11 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-10th 1946, at 9.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to May 10th 1946 and that I last saw h[im] alive on May 9th 1946

Immediate cause of death	DURATION
Odema Lungs	48 hrs
Due to: Chronic Brights Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J T Russell M. D. or other

Address: Earlton Md Date signed: 5-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (460)

CERTIFICATE OF DEATH

04513

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 west St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mat Koltyis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Tillie Koltyis

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 15 1876

8. AGE: Years 69 | Months 10 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Herbert Koltyis

13. Birthplace: Russia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Herbert Koltyis

Address: 22 State St annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26/46 (month) (day) (year)

Cemetery or crematory: Kneseth Israel

Location: Bert Gate

18. Funeral director: B L Hopkins

Address: annapolis Md

19. May 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/25 1946, at 5 ~~P~~ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/29 1945, to 5/25 1946 and that I last saw h. alive on 5/25 1946

Immediate cause of death	DURATION
Carcinoma of Stomach c	
Due to: metastitis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operations: Carcinoma of G.I. Tract c metastasis Date of op. 1/10/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Klaveno M.D.
M. D. or other

Address: Annapolis Md Date signed: 5.26.46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04513 28

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs, 6 mos, 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 7 yrs, 6 mos, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1147 North Mount Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: LEWIS - ESTHER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1915

8. AGE: Years	Months	Days	If less than one day
31	unknown		hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Frank Lewis
13. Birthplace: West Virginia

MOTHER
14. Maiden name: May Jones
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 8, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: George G. Kelson
Address: 1303 Presstman Street, Baltimore, Md.

19. 5-7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1946, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1938, to May 5, 1946, and that I last saw her alive on May 5, 1946.

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 2/15/45
Due to:	
Due to:	
Other conditions: Epilepsy with Psychosis	Known to us since 10/11/38

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 5/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04514

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: 1018 San Buren St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1018 San Buren

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: alice Wiley Linton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Clarence Linton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 26 - 1884

8. AGE:

Years	Months	Days	If less than one day
62	2	25	hrs. min.

9. Birthplace: Balto. md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: William Larkins

13. Birthplace: Balto md

MOTHER

14. Maiden name: Mary L McLerran

15. Birthplace: Balto md

16. Informant: W. Emerson Wiley

Address: Eastport Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23/46 (month) (day) (year)

Cemetery or crematory: Quaker

Location: Galesville md

18. Funeral director: B E Hopkins

Address: Annapolis Md

19. May 23 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 st 1946, at 9 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to May 21 1946

and that I last saw h.er alive on May 21 1946

	DURATION
Immediate cause of death: Myocarditis chr.	4 years
Uremia	3 days
Due to: Chr. Interstitial Nephritis	2 years
Due to:	
Other conditions: Arteriosclerosis	Several years
Duodenal Medicines	Several yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other

Address: Annapolis md Date signed: 5-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

04515

CERTIFICATE OF DEATH

★ Reg. Dist. No. 20

1. PLACE OF DEATH:

County a. a

City or town Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred: Oakwood ave 461 n

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Edgewater Post Office

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oakwood ave 461 n

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna May Lowe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	married

6.(b) Name of husband or wife Robert E Lowe

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct 17 — 1885

8. AGE: Years 60 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Erie Pa (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name William abbett

13. Birthplace England

MOTHER 14. Maiden name anna whelan

15. Birthplace England

18. Informant Robert E Lowe

Address woodland beach

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 3/46 (month) (day) (year)

Cemetery or crematory St marys

Location annapolis md

18. Funeral director B I Hopkins

Address annapolis md

19. June 3 19 46 Edward Culbreth (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1946, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to May 31, 1946

and that I last saw h... alive on May 31, 1946

Immediate cause of death	DURATION
(a) Carcinoma of the	Some
Due to (b) Uremia	1/12
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D. M. D. or other

Address Annapolis, Md Date signed 6/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04516 22

VS A15 — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Jessup (If outside city or town limits, write RURAL and give nearest town) Rural
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred: Champion Forest
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Jessup (If outside city or town limits, write RURAL and give nearest town) Rural
Street No.: Champion Forest. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Grace Malone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Marion R. Malone
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): December 5th 1903

8. AGE: Years: 42 | Months: 4 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: Chas. F. MacMurray
FATHER — 13. Birthplace: Washington, D.C.
MOTHER — 14. Maiden name: Ellen Boyle
MOTHER — 15. Birthplace: Donegal, Ireland.
16. Informant: Mr. Marion R. Malone
Address: Jessup, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/6/46 (month) (day) (year)
Cemetery or crematory: Cedar Hill, P.G. Co. Md.
Location:
18. Funeral director: Lloyd Kaiser
Address: Laurel, Md.
19. 5/4/46 (Date rec'd by registrar) 19 Registrar: Clara Kaslup

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th 1946, at 12:20 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4th 1946, to May 4th 1946 and that I last saw her alive on May 3rd 1946

Immediate cause of death	DURATION
Abdominal Carcinomatosis	3 mos.
Due to: Carcinoma of Ovary	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Ovary
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D. (M. D. or other)
Address: Savage, Md. Date signed: 5/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

04517

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, institution, or street address where death occurred: 118 - Tavenner South.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2613 Guilford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: Mrs. Carrie May Miller

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: Hewitt P. Miller

6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): May - 8 - 1863

8. AGE: Years	Months	Days	If less than one day
83	0	19	..... hrs. ..... min.

9. Birthplace: Baltimore Md.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: .....

FATHER — 12. Name: Jefferson Steigelman

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Elizabeth Helm

15. Birthplace: Maryland.

16. Informant: Miss Estelle Rice (cousin)

Address: Glen Burnie, Md.

17. Burial (Burial, Cremation, or Removal. Which?) Date thereof 5/29/46 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md.

18. Funeral director: William Cook Inc

Address: 127 St. Paul St.

19. 5/28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946, to May 27 1946 and that I last saw her alive on 5/26/46 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	9 days
Due to: Hypertension	?
Due to: Arteriosclerosis and senility	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Gustave H. Pauler M.D. M. D. or other

Address: Glen Burnie Md. Date signed 5/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

★ 04518 38

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs, 4 mos, 18 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 18 yrs, 4 mos, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war ---

3.(a) FULL NAME MOTEN - RICHARD PHILIP

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife Mary Moten, Rockville, Md.

6.(c) If alive, give age unk years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 32 | Months unknown | Days | If less than one day ___ hrs. ___ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Farm Worker

11. Industry or business ---

FATHER
12. Name John Moten
13. Birthplace Virginia

MOTHER
14. Maiden name Julia Nelson
15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 23, 1946 (month) (day) (year)

Cemetery or crematory Lincoln Park

Location Near Rockville, Maryland

18. Funeral director Robert L. Snowden

Address Rockville, Maryland

19. May 21 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1946 at 10:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945 1946 to May 20 1946 and that I last saw him alive on May 20 1946

Immediate cause of death	DURATION
General Paresis	Known to us since 1/2/44
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Herbert J. Thiroade M. D. or other

Address Crownsville, Maryland Date signed 5/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

04519

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5th Avenue.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William A. Nichols. Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife: Florence G. Nichols. Nee Gray
6.(c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): January 31, 1878

8. AGE: Years: 68 | Months: 3 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Connecticut (Town, county, and state)
10. Usual occupation: Wood Pattern Maker (Retired)
11. Industry or business:

FATHER
12. Name: George B. Nichols
13. Birthplace: Connecticut

MOTHER
14. Maiden name: Louella Fish
15. Birthplace: Connecticut.

16. Informant: Mrs. William A. Nichols
Address: Odenton Md. R.F.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie Md.

19. 5/7 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 46, at 10:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 46 to 5/4/46 19
and that I last saw him alive on 5/4/46 19

Immediate cause of death	DURATION
Cerebral Arteriosclerosis.	?
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave K. Beckenstein M. D. or other
Address: Glen Burnie Md. Date signed: 5/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04520 28

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs, 1 mo, 15 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 18 yrs, 1 mos, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1428 Bruce Street (If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: PENNINGTON - LENA

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1894

8. AGE: Years: 51 | Months: 11 | Days: 2 | If less than one day: ---hrs. ----min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: -----

FATHER
12. Name: Charles Pennington
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Byrd
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof 6-25-6 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt.
Address: Crownsville Md

19. June 3 19 46 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 46 at 4:50 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 10 19 28 to May 25 19 46
and that I last saw her alive on May 25 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Known to us since Feb. 1946
Due to: -----
Due to: -----
Other conditions: Psychosis with Mental Deficiency plus Alcoholism (Include pregnancy within 3 months of death) — Known to us since 4/10/28

Major findings of operations: -----
Date of op. -----
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of -----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

23. SIGNATURE: Herbert J Hostetter M. D. or other
Address: Crownsville, Maryland Date signed 5/25/46

04521

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 6 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 6 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 552 Dolphin Street (If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: PETTIFORD - IRENE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years: 52 | Months: unknown | Days: | If less than one day: ——— hrs. ——— min.

9. Birthplace: Michigan (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ———

FATHER
12. Name: Joseph A. Pettiford
13. Birthplace: Illinois

MOTHER
14. Maiden name: Mable A. Ridgeley
15. Birthplace: Michigan

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 14, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Kalamazoo, Michigan

18. Funeral director: Mrs. Frances A. Hemsley
Address: 578 West Biddle St., Balto., Md.

19. May 10 1946 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 19 46, at 6:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 19 45 to May 8 19 46 and that I last saw her alive on May 8 19 46

Immediate cause of death: General Paresis — DURATION: Known to us since 11/2/45
Due to: ———
Due to: ———
Other conditions: ———
(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Hyde Whitbeck M. D. or other
Address: Crownsville, Maryland Date signed: 5/8/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04522

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 59 Amos Garrett Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME L. Rosetta Phillips

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John J. Phillips

7. Birth date of deceased (mo., day, yr.) Oct 29 1868

6.(c) If alive, give age ..... years

8. AGE: Years 77 | Months 7 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Basil L. Gates

13. Birthplace Washington D C.

MOTHER 14. Maiden name Anna S. Garner

15. Birthplace Maryland

18. Informant Mrs V. Edgar Russell

Address 59 Amos Garrett Blvd Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21st 1946 (month) (day) (year)

Cemetery or crematory St Annes

Location Annapolis Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. May 21 1946 (Date rec'd by registrar) J. O. Lynch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1946, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 19 1946, to same date 19..... and that I last saw h.. alive on not 19.....

Immediate cause of death acute heart failure — DURATION about 2 years

Due to coronary heart disease angina pectoris

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Roeller M.D.
M. D. or other

Address 42 State Circle Annapolis Date signed 5-22-46

05302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey, County Monmouth.

City or town Parlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Union St.

(If rural, give LOCATION)

2.(a) If veteran, name war (Soldier, U. S. Army) ✓

3.(a) FULL NAME Charles Francis Pietch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/25/28

8. AGE:

Years	Months	Days	If less than one day
18	3	9	..... hrs. ..... min.

9. Birthplace Sayreville, N. J. (Town, county, and state)

10. Usual occupation Soldier.

11. Industry or business

FATHER

12. Name John Pietch

13. Birthplace Poland.

MOTHER

14. Maiden name Mary S. Salomon

15. Birthplace Poland.

16. Informant U. S. Army Records

Address Fort Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/4/46 (month) (day) (year)

Cemetery or crematory Matthew Maliszewski Funeral Home

Location New Brunswick, N. J.

16. Funeral director Howard N. Blight Jr.

Address 4914 Belair Road

19. 4 May, 1946 (Date rec'd by registrar) ALLAN G. BROTZMAN, 2d Lt., MAC, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd 1946 at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—

and that I last saw h— alive on ——— 19—

Immediate cause of death	DURATION
Compound fracture of skull -	Sudden
Due to Fell off Train P.R.R. No. 142	
Due to Struck Ground.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed as above in addition to*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

*ruptured heart, spleen and liver.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/1/46

Where did injury occur? Severn, A.A. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Railroad.

Means of injury Fell off train Injured at work? No

23. SIGNATURE Gustave K. Faubert M.D. M.D. or other

Address Glen Burnie, Md. Date signed 5/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

04523

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Telegraph Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edmund F. Edmiles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine T.
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Sept 8th 1877.

8. AGE: Years: 68. Months: 8. Days: 20. If less than one day: ... hrs. ... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Self
FATHER 12. Name: Richard R. Edmiles
FATHER 13. Birthplace: Md.
MOTHER 14. Maiden name: Mary M. Lowman
MOTHER 15. Birthplace: Md.
16. Informant: Mrs. Katherine T. Edmiles
Address: Telegraph Rd. Severn, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/1/46 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: 4300 Old Frederick Road.
18. Funeral director: John F. Cowan & Son
Address: 1501-03 Baltimore St.
19. 5/31/1946 Mrs. Alba Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/28/ 1946, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-27-46, 19... to 5-28-46, 19...
and that I last saw him alive on 5-28-46, 19...

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions: Angina Pectoris Cardiac Decompensation	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: [illegible] M. D., or other
Address: Edgewater Md. Date signed: May 30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5-45-15M

04524 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (304)

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A1A 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Eastern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: SCOTT - ARCHIBALD H.

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Elfrieda Scott, Eastern Ave., Chase, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): July 3, 1886

8. AGE:

Years	Months	Days	If less than one day
59	10	13	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: unknown

FATHER
12. Name: Archibald Scott
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosie ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 19, 1946 (month) (day) (year)
Cemetery or crematory: Sharp Street Cemetery
Location: Chase, Baltimore County, Maryland

18. Funeral director: Mrs. Rob. Elliott & Daughter
Address: 1129 N. Caroline St., Baltimore, Md.

19. 5/20/46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1946, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29, 1946, to May 16, 1946, and that I last saw him alive on May 16, 1946.

Immediate cause of death	DURATION
General Paresis	Known to us since 4/29/46
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op.: -------

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------- Injured at work? -------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 5/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

04525

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Dorsey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 10

Hospital, institution, or street address where death occurred: Forest Lane & Dorsey Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Dorsey

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Forest Lane & Dorsey Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Edna Rachel Seibert

3.(b) Social Security Number: 214-20-1435

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Walter Young Seibert

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Aug 21 - 1892

8. AGE:

Years	Months	Days	If less than one day
46	8	15	hrs. min.

9. Birthplace: Ebony Balto Co Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housework

12. Father's Name: Albert Taylor Hamilton

13. Father's Birthplace: Hertford Maryland

14. Mother's Maiden name: Margaret Hamilton

15. Mother's Birthplace: Hertford Maryland

16. Informant: Mrs Walter Y. Seibert

Address: Forest Lane & Dorsey Rd Dorsey

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/46 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Memorial Park

Location: Howard Co., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5-7- (Date received by registrar) 19 46 Registered Resale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 46 at 10 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 13 19 46, to May 6 19 46

and that I last saw h alive on May 5 19 46

Immediate cause of death: Carcinoma — DURATION: 3 yrs 10 mo

Due to: Carcinoma of Cervix — 6 mo

Due to: Uremia — 2 mo

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma

Date of op. May 6 - 46

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B B Brumbaugh M. D. or other

Address: Elkridge Md Date signed 5/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

04526

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Park.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Brooklyn Park.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 - 1st Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Smallwood.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed.

6.(b) Name of husband or wife: Rubin Smallwood

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19 - 1863

8. AGE: Years	Months	Days	If less than one day
82	6	8	hrs. min.

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Henry Huth

FATHER — 13. Birthplace: Balto. Md

MOTHER — 14. Maiden name: Not Known

MOTHER — 15. Birthplace: Not Known

16. Informant: Wm. Bryson

Address: 416 N. Port St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31-46 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cem.

Location: Eastern Ave.

18. Funeral director: John L. Miller

Address: 2334 Jefferson St.

19. 5/29 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1946, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1944, to 5/26 1946 and that I last saw her alive on 5/26/46 1946

Immediate cause of death	DURATION
Arteriosclerotic	
Heart disease	
Due to Generalized	
arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Rubin MD

M. D. or other

Address: 320 Potapsco Ave. Date signed: 5/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2 2

05311

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, institution, or street address where death occurred: District Training School
How long in hospital or institution? 2½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 4th St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Shirley Ann Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	s

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 7-30-38

8. AGE: Years 7 | Months 9 | Days 24 | If less than one day: hrs. min.

9. Birthplace: District of Columbia
(Town, county, and state)

10. Usual occupation: inmate

11. Industry or business

FATHER
12. Name: Irvin Smith
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mary Clyde Warren
15. Birthplace: D.C.

16. Informant: records of District Training School
Address: Laurel, Maryland

17. ~~removal~~ Burial Date thereof 5-24-46
(Burial, cremation, or removal) Which?) (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Md.

18. Funeral director: A. William Lee Sons Co
Address: 306 - 4 St N.E. DC

19. May 24 1946 Clara Harlick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 19 46 at 7:50p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-12-43 to 5-24-46 19
and that I last saw her alive on 5-24-46 19

Immediate cause of death	DURATION
bronchopneumonia	1 day
Due to:	
Due to:	
Other conditions: organic brain disease with mental deficiency and epilepsy	life

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Allen M Drummond MD M. D. or other
Address: District Training School Date signed 5-24-46

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

04527

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 years
Hospital, Institution, or street address where death occurred:
93 Calvert St. Annapolis Md.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 93 Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Walter Stevens

3.(b) Social Security Number: 214-05-0669

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Mrs Effie Stevens
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 3, 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Annapolis A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: None

FATHER
12. Name: Charles Stevens
13. Birthplace: Severn A. A. Co. Md.

MOTHER
14. Maiden name: Martha Ann Lee
15. Birthplace: Annapolis Md.

16. Informant: Mrs Effie Stevens
Address: 93 Calvert St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 / 9/46 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs. Chas. E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. May 9 19 46 (Date rec'd by registrar) Registrar: W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-5 1946, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16 1946, to 5-5 1946
and that I last saw him alive on 5-4 1946

	DURATION
Immediate cause of death: Lobar Pneumonia	
Cause:	
Due to:	
Due to:	
Other conditions: Senility & debility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. T. Allen M D
M. D. or other
Address: 17 Carroll St. Date signed: 5-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04528

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Regional Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? 3 Months and 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Germany County:
City or town: Halle/Saale Saxonia Landrain
(If outside city or town limits, write RURAL and give nearest town)
Street No. 152 A Germany
(If rural, give LOCATION)
2.(a) If veteran, name war: German Soldier (Prisoner Of War)

3.(a) FULL NAME: HERMANN STUHR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Liselotte Stuhr
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): February 2, 1910

8. AGE: Years	Months	Days	If less than one day
36	3	7	....hrs. ....min.

9. Birthplace: —
(Town, county, and state)
10. Usual occupation: Soldier, German Army (Cpl)
11. Industry or business: —
FATHER 12. Name: —
13. Birthplace: —
MOTHER 14. Maiden name: —
15. Birthplace: —
16. Informant: U.S. Army Medical and Service Records
Address: Ft. Geo. G. Meade, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/10/46 (month) (day) (year)
Cemetery or crematory: Post Cemetery
Location: Ft. Geo. G. Meade, Md., (Anne Arundel)
18. Funeral director: Howard N. Blight, Jr.
Address: 4914 Belair Road, Baltimore, 6, Md.
19. 10 May 1946 (Date rec'd by registrar) ALLAN G. BROTZMAN, 2d Lt., MAC (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 May 1946, at 1600 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 1946, to 9 May 1946, and that I last saw him alive on 9 May 1946.

Immediate cause of death	DURATION
Bronchopneumonia, cachexia and peripheral vascular collapse.	
Due to: Carcinoma of stomach, generalized peritonitis secondary to gastrectomy	
Due to: 26 April 1946.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 3 April 1946: Subtotal gastrectomy - (See other side) Date of op.
Autopsy results: Confirmed as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jerry B. Gwin
JERRY B. GWIN, CAPT., M.C. (M. D. or other)
Address: Reg. Hosp., Ft. Meade, Md. Date signed: 10 May 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Findings of operations (continued): Carcinoma of stomach.
26 April 1946: Total gastrectomy - Carcinoma of stomach.
8 May, 1946: Generalized peritonitis found on laporotomy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

04529

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: SWANN - THEODORE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Lydia Swann, Fairmount Heights, Maryland 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years: 34 Months: unknown Days: If less than one day: ---hrs. ---min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Trash Collector

11. Industry or business: ---

FATHER — 12. Name: unknown; 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown; 15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/18/46 (month) (day) (year)
Cemetery or crematory: St Ignatius
Location: Chapel Point Md

18. Funeral director: Hunt & Ryon
Address: Waldorf, Md

19. May 16 1946 E.T. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1946, at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 1946 to May 15 1946 and that I last saw him alive on May 15 1946

Immediate cause of death	DURATION
Fracture of skull,	6 hours
Fracture of both jaws	
Due to: Fracture of right knee	
Due to: General Paresis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/14/46
Where did injury occur? Crownsville, A.A., Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?), Crownsville State Hosp.
Means of injury: fall from 1st Story window Injured at work? no

23. SIGNATURE: John M. Claffey M.D. Deputy Medical Examiner
M. D. or Coroner
Address: Annapolis, Md. Date signed: 5/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

04530

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cherry Hill Lane & East End Drive
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Elwood Taylor

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hulda Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 2, 1874

8. AGE: Years	Months	Days	If less than one day
72	2	29	..... hrs. ..... min.

9. Birthplace Kent County Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Hulda Taylor
Address Orchard Beach, Md.

17. Burial Date thereof 5-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md.

18. Funeral director Geo. L. Schwab

Address 2101 Frederick Avenue

19. 5/2 1946 M. D'Alba
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1946 at 12:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to May 1 1946

and that I last saw him alive on April 30th 1946

Immediate cause of death

	DURATION
Cardiac Renal Failure	1 Day
Due to, Arteriosclerosis	
Due to, Hypertension, Chronic Endocarditis	two years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John L. Carmichael M. D. or other

Address Glen Burnie Date signed 5/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04531

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 17 Days -
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 - 11th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Matthew E. Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Margaret Thompson (nee Coppernale) 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 9, 1867

8. AGE:

Years	Months	Days	If less than one day
79	—	10	____ hrs. ____ min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Paper Cutter

11. Industry or business: Printing Business

FATHER
12. Name: Robert E. Thompson
13. Birthplace: New London, Conn.

MOTHER
14. Maiden name: Don't Know
15. Birthplace: Wash., D. C.

16. Informant: Mrs. Marie H. Treber (Daughter)
Address: 429 S. Charles St., Balto. 30, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem.
Location: Baltimore, Md.

18. Funeral director: C. Howard Evans
Address: 1405 S. Charles St., Balto. 30, Md.

19. 5/20 19 46 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19th, 19 46, at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb - 12 19 46 to May 19 19 46 and that I last saw him alive on May 18 - 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	3 mos.
Due to - Arteriosclerosis	6 mos
Due to - Gerard Anasarca	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: O. B. Wheeler M.D.
M. D. or other
Address: 1279 Hillsdale Date signed: 5/20/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04532

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Thirty-one days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Maryland
How long in hospital or institution? Thirty-One days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 144 Prince George Street, Annapolis, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Pasquale (n) TORANTINO

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Flora Torantino (Wife)
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): January 6 1868

8. AGE: Years	Months	Days	If less than one day
78	3	28	...hrs. ...min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Ch. Musician Retired Inactive USN
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Flora Torantino (Wife)
Address: 144 Prince George Street, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8th 1946 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Maryland
18. Funeral director: John M. Taylor & Sons
Address: Annapolis, Maryland

19. May 7 1946 (Date rec'd by registrar) Registrar: J. T. O'Donnell

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-4 1946, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-3 1946 to 5-4 1946 and that I last saw h.l. alive on 5-4 1946

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to: Arteriosclerotic Heart Disease	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Frank H. Thomas Lt (MC) USN M. D. or other
Address: USNH, Annapolis, Md. Date signed: 5-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Va)

04523

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:
28 Calvert St. Annapolis Md.

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 Calvert St. Annapolis Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Nettie Watts

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Joseph Watts

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 20, 1896

8. AGE: Years: 50 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Gaylesville A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John Edwards
13. Birthplace: Millswamp A. A. Co.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Mary Johnson
Address: 91 Shaw St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/23/46 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St extd. Annapolis Md.

18. Funeral director: Mrs Chas. E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. May 23 1946 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1946 at 6:20 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from May 16 1946 to May 19, 1946

and that I last saw h[illegible] alive on May 19, 1946

Immediate cause of death	DURATION
Acute Myocarditis	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Rob. Richardson M. D.

Address: Annapolis Md. Date signed: 5/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

04534

Reg. Dist. No. 21

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: ANNE ARUNDEL

City or town: RURAL – NEAR SEVERN
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: POST OFFICE – SEVERN, MD.

Stay in hospital or inst. (yrs., or mos., or days): NONE

Stay in this community (yrs., or mos., or days): 16 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ANNE ARUNDEL

City or town: RURAL – NEAR SEVERN, MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1 MILE FROM SEVERN
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: BERTHA ELIZABETH WEBER

3. (b) Social Security Number: 216-10-4548

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband ~~or wife~~: GEORGE B. WEBER

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): DECEMBER 21, 1896

8. AGE:

Years	Months	Days	If less than one day
49	4	27	____ hrs. ____ min.

9. Birthplace: HILLSBORO, QUEEN ANNE COUNTY
(Town, county, and state)

10. Usual occupation: SEAMSTRESS

11. Industry or business: CROWNSVILLE STATE HOSPITAL

FATHER
12. Name: JOHN BYARD
13. Birthplace: QUEEN ANNE COUNTY, Md.

MOTHER
14. Maiden name: SARA ELIZABETH GIBSON
15. Birthplace: QUEEN ANNE COUNTY, Md.

16. Informant: MR. GEORGE B. WEBER
Address: P.O. SEVERN, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1946 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Md.

18. Funeral director: E. Willis Lamoreux

Address: 1003 W. Baltimore St.

19. 5/22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 18 1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 MAY 1946, to 18 MAY 1946, and that I last saw her alive on 17 MAY 1946.

Immediate cause of death	DURATION
RESPIRATORY FAILURE	
Due to CEREBRAL HEMORRHAGE	
Due to HYPERTENSION	
Other conditions RIGHT HEMIPLEGIA AND RIGHT VERTICAL STRABISMUS ONSET	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry F. Zangara, M.D.
M. D. or other

Address: 401 W. Annapolis Blvd. Date signed: May 18, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

04535

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME WEBSTER - SADIE STANSBURY

3. (b) Social Security Number ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 70 Months: unknown Days: If less than one day: --- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 31, 1946 (month) (day) (year)
Cemetery or crematory: Union M. E.
Location: Aberdeen, Maryland

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Maryland

19. May 28 1946 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 46 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 46 to May 28 19 46 and that I last saw her alive on May 28 19 46

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 5/15/46
Due to: ------	
Due to: ------	
Other conditions: Psychosis with Cerebral Arteriosclerosis - Syphilis (Include pregnancy within 3 months of death)	Known to us since 5/15/46

Major findings of operation: ------ Date of op.: -----
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: -----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? -----

23. SIGNATURE: Ethel J. Anderson M. D. or other
Address: Crownsville, Maryland Date signed: 5/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

AGE: Balto. City birth cer.
Inf: funeral director in person. - 5-6-46 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04536
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 7 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1025 Cloney Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: WILLIAMS - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: ROSE ////// Nellie Williams, 1025 Cloney St., Balto., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1905? Dec. 21 1908

8. AGE: Years	Months	Days	If less than one day
37 1943?	4 unknown	11	---hrs. ---min.

9. Birthplace: ////// unknown Baltimore City Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Coal trucking

FATHER
12. Name: ////// unknown JOHN A. WILLIAMS
13. Birthplace: ////// unknown MD.

MOTHER
14. Maiden name: ////// unknown SARAH SUMMERFIELD
15. Birthplace: ////// unknown MD.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 1946 (month) (day) (year)
Cemetery or crematory: M.P. Asylum Cem.
Location:

18. Funeral director: Mrs Nadie R. Williams
Address: 322 N. Schroeder St

19. 5/6/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 19 46 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 46 to May 2 19 46 and that I last saw him alive on May 2 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 2/25/46
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: ----------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: ----------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ----------

23. SIGNATURE: Herbert A. Winbrooder M. D. or other
Address: Crownsville, Maryland Date signed: 5/2/46

9697

Williams - John
Baltimore City
Admitted - February 25, 1946

Died - May 2, 1946

04537

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1009 Jackson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Brooke Willson

3.(b) Social Security Number: 214-05-0504

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Edith V. Willson
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14th 1884

8. AGE: Years	Months	Days	If less than one day
61	11	19	hrs. min.

9. Birthplace: Rock Hall - Calvert - Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: James B. Willson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Gertrude Stephens
15. Birthplace: Maryland
16. Informant: Leonard Willson
Address: 1009 Jackson St. - Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6th 1946 (month) (day) (year)
Cemetery or crematory: Asbury Church Cemetery
Location: Calvert County Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. May 6, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 1946, at 6P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to May 5 1946
and that I last saw h... alive on May 5 1946

Immediate cause of death: Cerebral Hemorrhage

	DURATION
Due to: Hypertensive Cardio Vascular	
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. Lunt M. D. or other
Address: Eastport Md. Date signed: May 6 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.